Health Insurance Connecticut
Box 896 Ridgefield, CT 06877
Phone: (800) 870-6881
Fax: (800) 870-6881
Email: healthinsuranceconnecticut@hotmail.com

How To Apply By Mail – ConnectiCare Insurance Company

(ConnectiCare currently DOES NOT offer instant online Applications)

Step 1 – Application Process

Please print out all Application Forms. Enter appropriate complete information where requested. Please be sure to double check every line for completeness of information. When applying with your spouse or domestic partner, **be sure to list the younger adult as the Applicant**. Rates partly based upon Applicant age.

EFT Form needs to be completed for ongoing monthly drafts.

If you have questions, need assistance, please contact us at **(800) 870-6881**.

Step 2 – Let Us Proof Your Application

This is an optional step. Before sending your Application to ConnectiCare, please email, or fax your completed Application to us at **(800) 870-6881**. An error or omission can delay the Application process by several weeks.

We will contact you **only after** we receive your Application and review for any necessary corrections.

Step 3 – Apply By Mail

You will need to send your signed, completed Application along with the first month's premium, directly to ConnectiCare. The mailing address is:

ConnectiCare, Inc.
Attn: Solo
175 Scott Swamp Road
Farmington, CT 06034-4050

If you have any questions, need assistance, please contact us at **(800) 870-6881**.

Thank you for your time and effort.

John W. Kaffka

STEPS TO APPLY

ConnectiCare, Inc. & Affiliates

Steps to Apply – ONLINE:

For added convenience, you can apply for ConnectiCare SOLO online. Your ConnectiCare Agent will send you an e-mail invitation that provides detailed information about the online enrollment process. Or, you can go directly to **connecticare.com/solo** to apply or get a quote yourself. Remember to select your agent from the list provided. Plus, you will be able to check online for an updated status of your application once it's submitted.

Online application has these advantages:

- It expedites the process because the Individual Application Packet (Parts 1-3) goes directly to our underwriting department.
- It helps to prevent you from leaving out necessary information.
- No postage is required.
- No mail delays or lost mail.
- It helps the environment by using less paper.

Steps to Apply – PAPER:

APPLICANTS MUST:

1) **Complete, sign and date the Individual Application/Change Form – PART 1 – no more than 60 days prior to the requested effective date.** Be sure to:
   a. Check the box for the medical and dental plan being selected.
   b. Check the boxes for the pharmacy co-pay and pharmacy annual maximum that are being selected (does not apply to HDHP plans).
   c. Select a Primary Care Physician (PCP) for each family member applying for coverage and write the PCP name and Provider ID number in the appropriate boxes. For a complete list of participating providers and their ID numbers, go to connecticare.com/providerdirectory. To request a paper copy of the Provider Directory, call Member Services at **1-800-251-7722.**
2) **Accurately and completely answer** all questions on the Individual Health Statement – **PART 2** – for each family member applying for coverage.

If the applicant knowingly provides false information and/or omits information on the application or health statement and such information submitted or omitted materially affects the risk assumed by ConnectiCare, ConnectiCare will seek to have the policy rescinded.

3) Complete, sign and date the Underwriting Authorization Form – **PART 3**.
4) For dependents under age 18, the application must have a parent's/guardian's signature and date – and the parent's/guardian's full name must be printed on the application. Dependents age 18 and over must sign and date the application themselves.

   Note: Persons under age 19 may not apply for coverage as a subscriber.
5) All completed forms must be signed, dated and received at ConnectiCare by the last day of the month for an effective date on the 1st of the next month. (i.e. A complete application received by January 31st would be eligible for a February 1st effective date. A complete application received on February 1st would be eligible for a March 1st effective date. *Please note that if the application is approved in these scenarios, at least two months of premium will be due right away.)*

Steps to Apply – ONLINE or PAPER:

6) **You do not have to submit your first premium payment with your application.** However, once you are approved, all premiums from the effective date of coverage are due by the first of the month following the date of the approval letter, or the effective date of the policy, if later. This could mean that you could owe us more than one month of premium and owe the premium quickly. All premiums not received by the first of the month for the month of coverage are considered past due. This applies to all premium payment methods – check, Electronic Funds Transfer (EFT) and credit card.

6a) To elect paying your premium via EFT you will need to wait until your application has been approved and the policy is in effect. There are two ways to elect EFT:

- Once you receive your first invoice, you can sign the return portion of your invoice and return it with your first premium payment. For future payment drafts, we will use the checking account number that appears on the check you submit for initial premium payment. Please be advised that it takes up to 30 days to set up your new EFT information.
- You may also elect EFT by registering as a member on connecticare.com. Once you register as a member you can use the member site to elect EFT. Under My Information select Pay My Bill/Billing Information, select Add EFT. Fill out the required fields and click on Save. Please be advised that it takes up to 30 days to set up your new EFT information.

6b) To pay your premium by credit card:

Log on to the secure member section of our website at **www.connecticare.com/members.** Click on "Pay My SOLO Premium" under the "Member Quick Tools" on the left menu.

You will need to sign on to the website with a username and password to activate payment by credit card. If you are new to the website, you will need to register first to gain access. Go to https://secured.connecticare.com/register.asp to register.

To continue paying your premium by credit card on an ongoing basis, you will need to log on to the site and activate payment each month.

6c) To pay your premium by check:

Mail payments to:
ConnectiCare, Inc.
P.O. Box 416191
Boston, MA 02241-6191

7) If applicable, complete the Domestic Partner Verification Form or other satisfactory certification as we determine.

8) Effective dates for coverage are the first of the month following the date we receive your complete application.

Acceptance into the plan is based on our review of the Individual Health Statement(s) and the applicant meeting the eligibility requirements and underwriting criteria. As part of our medical underwriting, ConnectiCare may need access to your medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician's office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete, and will be withdrawn if you do not arrange to have the medical records provided to us within 45 days of the request. For additional copies of ConnectiCare SOLO forms, contact your Agent or call Member Services at **1-800-251-7722**.

9) Final rates are subject to change based on a client's medical history, correct ZIP code, ConnectiCare's underwriting guidelines, state and federal regulations and effective date of coverage.

ConnectiCare, Inc. & Affiliates Individual Application/Change Form Part 1 (page 1 of 3)

P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-251-7722

APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side.

Check one: ☐ New Application ☐ Add Dependent ☐ Change Ind. Plan Choice (select new choice below) Eff. Date (mm/dd/yyyy) / /
☐ Other (Name change, address change, etc.) Indicate change _____

Marital Status: ☐ Single ☐ Married (Civil Union) ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Divorced ☐ Domestic Partnership (include "Statement of Domestic Partnership") E-mail Address

Street Address Primary Telephone Number ☐ Home ☐ Mobile ☐ Work

City State Zip Code Secondary Telephone Number ☐ Home ☐ Mobile ☐ Work

P.O. Box/Billing Address (if different from street address) City State Zip Code

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number or Current Member Identification Number	Sex	Date of Birth (mm/dd/yyyy)	Primary Care Provider	Provider ID Number (6 or 8 digits)	Existing Patient
Race/Ethnicity (optional): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment.								
Applicant			__ __ __ __ __ __ __ __ __	☐ M ☐ F	/ /		__ __ __ __ __ __ __	☐ Yes ☐ No
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown								
Spouse/Civil Union/Domestic Partner			__ __ __ __ __ __ __ __ __	☐ M ☐ F	/ /		__ __ __ __ __ __ __	☐ Yes ☐ No
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown								
Dependent 1			__ __ __ __ __ __ __ __ __	☐ M ☐ F	/ /		__ __ __ __ __ __ __	☐ Yes ☐ No
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown								
Dependent 2			__ __ __ __ __ __ __ __ __	☐ M ☐ F	/ /		__ __ __ __ __ __ __	☐ Yes ☐ No
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown								
Dependent 3			__ __ __ __ __ __ __ __ __	☐ M ☐ F	/ /		__ __ __ __ __ __ __	☐ Yes ☐ No
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Unknown								

ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans

POS Benefit Plans (Select one)
(In-Network Deductible=Individ./Family):

- ☐ POS Hospital Deductible $2,500/$5,000 – **D**
- ☐ POS Upfront Deductible $500/$1,000 – **D**
- ☐ POS Upfront Deductible $1,000/$2,000 - **D**
- ☐ POS Upfront Deductible $1,500/$3,000-20% – **D**
- ☐ POS Upfront Deductible $2,500/$5,000 – **D**
- ☐ POS Upfront Deductible $2,500/$5,000-30PCP–50%– **D**
- ☐ POS Upfront Deductible $5,000/$10,000 – 20% – **D**
- ☐ POS Hospital Deductible $5,000/$10,000 – **D**
- ☐ POS Upfront Deductible $750/$1,500 – **D**
- ☐ POS Upfront Deductible $1,000/$2,000–30PCP–50% – **D**
- ☐ POS Upfront Deductible $2,000/$4,000 – **D**
- ☐ POS Upfront Deductible $2,500/$5,000 – 20% – **D**
- ☐ POS Upfront Deductible $5,000/$10,000–30PCP–50%- **D**
- ☐ POS Upfront Deductible $10,000 Combined – **D**

Pharmacy Co-Pay (Select one):
☐ $15 / 50% / 50% $200 Deductible T2/T3 ☐ No RX

SOLO Dental:
☐ $25 Deductible, 100%/0%/0%, unlimited max, no ortho

OR

HSA Compatible Plans
(Select one HMO plan or POS plan)
(Deductible=Individual/Family):

HMO HDHP
☐ $5,000/$10,000 Deductible – **D**

POS HDHP
☐ $1,500/$3,000 Deductible – **D**
☐ $2,000/$4,000 Deductible – **D**
☐ $3,000/$6,000 Deductible – **D**
☐ $5,000/$10,000 Combined Deductible – **D**

Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? ☐ Yes ☐ No

Name of other insurance company Type of coverage ☐ Employer ☐ Individual

Do you intend to replace your current medical or health policy with this policy? ☐ Yes ☐ No

AGENT SECTION:	
Agency Name: Health Insurance Connecticut	Phone Number: (800) 870-6881
Agent Name (Print): John W. Kaffka	▶ Agent Signature: John W. Kaffka

FOR BUSINESS USE ONLY:	
Effective Date	
Account #	Other

F014 0912

DISCLOSURE OF MEDICAL LOSS RATIO

The State Medical Loss Ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with applicable law.

The Federal Medical Loss Ratio has the same meaning as provided in and calculated in accordance with PPACA, PL 111-148, as amended from time to time, and regulations adopted thereunder.

- **State Medical Loss Ratio for calendar year 2011 for ConnectiCare, Inc. (CCI):** 81.3%
- **Federal Medical Loss Ratio for calendar year 2011 for ConnectiCare, Inc. (CCI):** 85.7%
- **State Medical Loss Ratio for calendar year 2011 for ConnectiCare Insurance Company, Inc. (CICI):** 73.3%
- **Federal Medical Loss Ratio for calendar year 2011 for ConnectiCare Insurance Company, Inc. (CICI):** 82.2%

Important: [The applicant, spouse/partner and all dependents aged 18 and over must sign this form]. By [selecting I (we) agree] signing here I acknowledge and agree that I have read and understand the information on the front **and back** of this form and Part 2: Health Statement. I also agree that the Member Consent below is valid as long as I am enrolled in a ConnectiCare health plan. I certify that I have personally completed this application on behalf of myself and on behalf of my dependents listed on the application who are under the age of 18. I represent that the answers and statements made herein and in Part 2 Health Statement are true, complete and correctly recorded to the best of my knowledge and belief. I understand that I have an obligation to notify ConnectiCare of any new conditions or changes in health condition that may occur after this application is signed and before the effective date of my policy. I acknowledge that I have received a copy of the Outline of Coverage for the Plan I have selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. I further understand and agree that: (1) ConnectiCare may decline my application and that this application and the initial premium do not give me immediate coverage; (2) the broker has no authority to promise coverage or to modify ConnectiCare's underwriting policy and is only authorized to submit this application and the initial premium payment; (3) if I have knowingly provided incorrect or incomplete information on this application and/or Health Statement that ConnectiCare may rescind any policy within 2 years of issuance. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and Health Statement and that if I am accepted that this application/Health Statement will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract.

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

► _____

Applicant Signature Date

_____

Print name of parent/guardian (if applicable)

► _____

Dependent Signature (age 18 years-over) Date

► _____

Spouse/Partner Signature (if applicable) Date

► _____

Dependent Signature (age 18 years-over) Date

STATEMENT OF ACCOUNTABILITY

To be completed when the applicant cannot complete the application.

I, _____ , personally read and completed this Application/Health Statement for the applicant named below because: ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): _____

I am qualified to translate the contents of this form and translated this information to: _____

To the best of my knowledge I obtained and listed all the requested personal and medical history disclosed by this applicant. I also translated and fully explained the statements above.

► _____

Signature of Translator (required) Today's Date

IMPORTANT: MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliate, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, conducting investigations, meeting CCI's contractual obligations and performing other operations to administer my Benefit Plan. I understand that CCI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I have the right to revoke this authorization of release of medical records at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I understand that, if I exercise such right, CCI may not be able to settle a claim, and CCI can terminate my insurance policy because my revocation of authorization prevents CCI from paying claims, conducting an investigation, meeting CCI's contractual obligations and/or performing other operations to administer my Benefit Plan. I acknowledge that I have retained a copy of this authorization.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

Any new conditions or changes occurring after the application is submitted but prior to approval, must be reported to ConnectiCare.

P.O. Box 4058, Farmington, CT 06034-4058 ▪ www.connecticare.com ▪ 1-800-251-7722

PLEASE PRINT IN INK AND COMPLETE BOTH SIDES OF FORM FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE.

First Name/Middle Initial/Last Name	Height (ft/in)	Weight (lbs.)	Date of Birth (mm/dd/yyyy)	Sex	Social Security #
Applicant			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __
Spouse/Partner			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __
Occupation Applicant / Occupation Spouse/Partner					
Dependent 1			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __
Dependent 2			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __
Dependent 3			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __
Dependent 4			/ /	☐ M ☐ F	__ __ __ __ __ __ __ __ __

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

In the last 10 years, has any person applying for coverage on this application: 1) had any signs or symptoms, 2) seen a health care provider, 3) had treatment recommended, including prescription medications, 4) received treatment, 5) had the diagnosis of, or 6) been hospitalized for, any of the following conditions?

DO NOT INCLUDE ANY GENETIC INFORMATION IN YOUR RESPONSE. "GENETIC INFORMATION" INCLUDES:

- **INFORMATION ABOUT GENETIC TESTING OF ANY APPLICANT OR OF ANY APPLICANT'S FAMILY MEMBERS;**
- **ANY MEDICAL HISTORY INFORMATION ABOUT ANY FAMILY MEMBER NOT APPLYING FOR COVERAGE; AND**
- **ANY GENETIC SERVICES REQUESTED OR RECEIVED BY ANY APPLICANT OR ANY APPLICANT'S FAMILY MEMBERS.**

1. **Brain/Nervous System –** such as frequent and/or severe headaches, migraines, seizures, epilepsy, recurrent numbness/tingling, restless leg syndrome, head injury with loss of consciousness, paralysis, stroke, memory loss, narcolepsy, use of a sleep monitoring device? ☐ Yes ☐ No
2. **Heart/Circulatory –** such as chest pain, angina, heart disease, cardiomyopathy, heart attack, heart murmur, valve problem/ replacement, pacemaker, defibrillator, or blood clot, phlebitis, varicose veins, rheumatic fever, Raynaud's, irregular heart beat? ☐ Yes ☐ No
3. **Blood Disorder/Problems –** such as high blood pressure, hyperlipidemia (cholesterol, liver functions, triglycerides) blood clotting problem, bleeding disorder, anemia or other blood disorders? ☐ Yes ☐ No
4. **Lungs/Respiratory –** such as sleep apnea, chronic obstructive pulmonary disease (COPD), emphysema, asthma, allergies, difficulty breathing, shortness of breath, pneumonia, tuberculosis, chronic cough, spitting/coughing up blood, sinusitis, bronchitis, use of portable oxygen? ☐ Yes ☐ No
5. **Digestive –** such as colitis, hepatitis, liver disease, cirrhosis, rectal bleeding, infections of the mouth/throat/jaw, chewing problems, gastric reflux (GERD), frequent heartburn, Barrett's Esophagus, Crohn's, ulcers, hernia, polyps, hemorrhoids, gallbladder disease including gallstones, pancreatitis, jaundice, unexplained weight loss? ☐ Yes ☐ No
6. **Urinary –** such as renal failure, ESRD, kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, prostate problems? ☐ Yes ☐ No
7. **Muscle/Bone/Joint –** such as bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, physical handicap, polio, spina bifida, arthritis, gout, sprain/strain, prosthesis, joint replacement, internal fixations or hardware (i.e., pins, plates, screws), fractures, TMJ disease of the jaw, chronic back, neck, shoulder, hip, knee, hand or foot pain? ☐ Yes ☐ No
8. **Endocrine/Hormonal –** such as diabetes, thyroid disease, adrenal disorders or pituitary disorders? ☐ Yes ☐ No
9. **Infectious/Immune –** such as Lupus, HIV, immune disorders, scleroderma, Epstein-Barr virus/chronic fatigue syndrome, chronic Lyme Disease or lymph node disorder? ☐ Yes ☐ No
10. **Skin Disorder –** such as any kind of skin cancer, melanoma, psoriasis, actinic keratosis, disfiguring birthmarks, 3rd-degree burns, acne, fungal infections, eczema, dermatitis, herpes, shingles, scars/keloids, or revisions of cosmetic or reconstructive surgery, chronic skin infections? ☐ Yes ☐ No
11. **Ears, Eyes, Nose and Throat –** such as any infections, deafness, crossed eyes, chronic dry eye requiring treatment, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea? ☐ Yes ☐ No
12. **Mental, Emotional, Behavioral, Substance Use –** such as schizophrenia, bi-polar, chemical imbalance, obsessive-compulsive disorder, panic disorder, anxiety, attention deficit disorder (ADD), depression, psychological or psychiatric counseling, anorexia/bulimia, eating disorder, or alcohol or substance use/abuse/dependency? ☐ Yes ☐ No

(continued on next page)

Part 2
(page 2 of 3)

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

APPLICANT NAME: _____ **APPLICANT SOCIAL SECURITY #** _____

QUESTIONS, CONTINUED FROM PAGE 1. For "YES" answers, details must be provided below under the "Health History" section.

13. Developmental/Congenital Abnormalities, Birth Defects – such as Down's syndrome, mental retardation, developmental delay, skull/facial deformities, heart/lung problems, cleft lip/palate, spina bifida, club foot, webbed fingers or toes, disfiguring birthmark? ☐ Yes ☐ No

14. Cancer, of any kind – such as skin cancer, colon cancer, breast cancer, throat cancer, ovarian cancer, uterine cancer, prostate cancer, leukemia, Hodgkin's disease, lymphatic cancer, bone cancer, bone marrow cancer, any other cancers, tumors, or lymph node enlargement? ☐ Yes ☐ No

15. Male Reproductive System (all men must respond)

a) such as: infertility treatment/services (currently, in the past, planned or recommended) with anyone, whether or not listed on this application, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted diseases, herpes, genital warts, undescended testes? ☐ Yes ☐ No

b) Are you expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? If yes, please provide the expected delivery/adoption date: _____ ☐ Yes ☐ No

16. Female Reproductive System (all women must respond)

a) such as: infertility treatment/services (currently, in the past, planned or recommended) with anyone, whether or not listed on this application, breast disorder/cyst, lump, silicone breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent or irregular menstrual bleeding, uterine fibroids, ovarian cysts, miscarriages, sexually transmitted diseases, herpes, genital warts, Human Papillomavirus? ☐ Yes ☐ No

b) Does any proposed female applicant menstruate? ☐ Yes ☐ No
Name(s): _____

c) Has it been more than 40 days since her/their last menstrual period? ☐ Yes ☐ No
Name(s): _____
If yes, explain: _____

d) Has any female applicant over age 16 had a pelvic exam/Pap smear? ☐ Yes ☐ No
If yes, provide the date and result of the last pelvic exam/Pap smear: Name(s): _____
Mo/Day/Yr: _____ Normal ☐ _____ Abnormal ☐ _____

e) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No
If yes, please provide the expected delivery/adoption date: _____

17. In the last 10 years, has any applicant:

a. ever been a candidate for, or a recipient of a bone marrow transplant or organ transplant, including cornea transplant? ☐ Yes ☐ No

b. been placed on a waiting list and/or registered to donate an organ or bone marrow (excluding DMV donor card)? ☐ Yes ☐ No

c. ever had any non-malignant (benign) tumor/growth or cysts? ☐ Yes ☐ No

d. ever been diagnosed with obesity and/or have a problem with weight control or had bariatric surgery? ☐ Yes ☐ No

e. been a patient in a hospital, clinic, surgicenter, or other medical facility as an inpatient or outpatient (excluding childbirth)? ☐ Yes ☐ No

f. had health, disability, long-term care or life insurance declined, modified, postponed or rated? ☐ Yes ☐ No

g. been disabled or unable to perform their normal activities, or require the use of any assistive devices including a wheelchair, walker, portable oxygen, etc.? ☐ Yes ☐ No

h. been told by a medical professional, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS-related conditions? ☐ Yes ☐ No

i. ever smoked or used tobacco products? ☐ Yes ☐ No
If yes, who and for how long? _____
If no longer smoking/using tobacco, date of last cigarette/tobacco use? _____

j. had an abnormal physical exam, laboratory results, X-rays, EKG, MRI, CT Scan, PET Scan, ultrasound, cardiac testing, or results that have not yet been communicated? ☐ Yes ☐ No

k. ever been advised, suggested to or scheduled to undergo further testing, surgery, consultation or treatment? ☐ Yes ☐ No

l. had any surgical procedures? ☐ Yes ☐ No

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

(continued on next page)

APPLICANT NAME: _____ **APPLICANT SOCIAL SECURITY #** _____

QUESTIONS, CONTINUED FROM PAGE 2.

18. In the past 5 years has any applicant taken, or been advised to take, any prescription medications or prescription food supplements on a long-term basis (for longer than 1 month)? ☐ Yes ☐ No

19. In the past 12 months has any applicant been advised to see a dentist or oral surgeon (excluding routine checkups)? ☐ Yes ☐ No

20. Has any applicant applying for coverage had any medical problems which have not been disclosed on this Health Statement? ☐ Yes ☐ No

21. In the past 12 months has anyone been treated for any injuries? If so, please provide date of injury, first date of treatment, recovery date and detail of injury/accident. ☐ Yes ☐ No

22. Last doctor visit for any reason, including routine checkup in the last 3 years (excluding dental or eye exam). Provide information for all applicants.

Name	Reason for Visit	Date of Visit	Results	Physician

A detailed explanation must be provided below if you answered "YES" to any question (1-21). NOTE: Simply listing the name of a primary physician or referring to a physician's name will be not be considered a substitute for listing fully detailed answers to the questions. If additional space is needed, you may attach a separate page, which must be signed and dated.

HEALTH HISTORY:

Question Number/Ltr.	Person Affected	Condition/Diagnosis	Type of Treatment (surgeries, name of medication, counseling, other)	Date Treatment Began	Date of Full Recovery	Physician Name, Address & Phone Number

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections, and sign and date the application and underwriting authorization form (ages 18 and older)?**
- ☐ **Select your primary care physician and include the 6- or 8-digit Provider ID number? (It can be found at www.connecticare.com/providerdirectory)**
- ☐ **Attach Domestic Partner Verification Form or other satisfactory certification as we determine (if applicable)?**
- ☐ **Retain a signed copy for your records?**

*** By my signature on Part 1, I certify that the statements made herein and in Part 1 are true and complete to the best of my knowledge and belief. Any health conditions that change after the application is submitted but prior to notice of approval, must be reported to ConnectiCare and will be considered in the final underwriting decision.**

ConnectiCare, Inc. & Affiliates Underwriting Authorization Part 3

Note: You and any dependents aged 18 or over must sign this form along with the completed Individual application form. If we do not receive this signed form, the application will be considered incomplete and could be delayed. Further, as part of our medical underwriting, ConnectiCare may need access to medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician's office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete and may be withdrawn if you do not arrange to have the medical records provided to us within forty-five days of such request.

NAMES OF APPLICANT(S):	
Primary Applicant	Applicant Social Security Number
Spouse/Partner	Dependent Applicant aged 18 or over
Dependent Applicant aged 18 or over	Dependent Applicant aged 18 or over

AUTHORIZATION:

I hereby authorize any health care provider, medical facility, pharmacy, pharmacy benefits company or pharmacy related facility, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested by ConnectiCare.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy, prescriptions, HIV testing and treatment, STD testing and treatment, lab data and EKGs. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by ConnectiCare pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable ConnectiCare to make eligibility determinations relating to me and/or my minor children and for ConnectiCare's underwriting or risk rating determinations. If I refuse to sign or choose to revoke this authorization, ConnectiCare may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying ConnectiCare in writing of my desire to revoke. Such revocation must be sent to the following address: ConnectiCare, Inc., Underwriting Department, 175 Scott Swamp Road, Farmington, CT 06034. Such revocation will not be valid if ConnectiCare has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, or, if insured, when I am no longer an insured of ConnectiCare.

Any health conditions that change after the application is submitted but prior to notice of approval, must be reported to ConnectiCare.

▶ _____ Date
Signature of Primary Applicant or Representative*

▶ _____ Date
Signature of Spouse/Partner or Representative*

▶ _____ Date
Signature of Other Dependent Applicants aged 18 or over or Representative*

▶ _____ Date
Signature of Other Dependent Applicants aged 18 or over or Representative*

▶ _____ Date
Signature of Other Dependent Applicants aged 18 or over or Representative*

* If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.

UND 0912